



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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COMMISSIONER

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES

Effective Date: Monday, May 6, 2002

COMMISSIONER'S POLICY STATEMENT NO. 22-A: SECLUSION UTILIZATION

This policy has been written to conform with Connecticut General Statutes Section 17a-540-17a, 550, State of Connecticut, Public Act 99-210, and HCFA Conditions of Participation: Interim Final Rule (HCFA 3018-IFC: (f) Standard: Seclusion and Restraint for Behavioral Management), and JCAHO Standards for Behavioral Health; *May 3, 2000*

It is the expectation of the Office of the Commissioner that each facility that utilizes seclusion shall have a written policy and procedure that governs the use of seclusion that is appropriate to its needs. This policy statement serves as the guideline to be used in the drafting of a policy and procedure by the individual facilities. *(See Page 10 for details on facility policy and procedure development)*

PHILOSOPHY

The Department of Mental Health and Addiction Services is committed to providing comprehensive, individualized psychiatric and substance abuse care in safe recovery environments. These environments shall foster a culture of respect, dignity, collaboration, and self-determination. Wellness, rehabilitation, and recovery shall be the over-arching principles guiding all interventions. Within this framework, DMHAS believes that people have the right to be free from the use of seclusion except as an emergency intervention to prevent immediate or imminent physical injury. Non-physical and less restrictive interventions are preferred as the first intervention, unless they have been determined to be ineffective or when safety issues require an immediate response.

The department makes every effort to alleviate the need to employ emergency safety measures. Administrative and clinical leadership articulates this philosophy at all levels through the use of (1) patient-centered care plans that thoughtfully integrate strengths, needs, cultural determinants, and personal preference; (2) clinical staff who are trained and skilled in using preventive and early intervention alternatives, especially conflict resolution strategies; and (3) performance improvement programs that identify the factors that contribute to the use of seclusion and are focused on the elimination of seclusion.



DEFINITIONS:

Seclusion. The involuntary confinement of a person in a room or an area whether alone or with staff supervision in which he/she is physically prevented from leaving.

Licensed Independent Practitioner (LIP). A licensed person who is permitted by law and by the facility to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with granted clinical privileges.

POLICY

Systems of care that encourage collaboration and respect shall serve as the foundation for the Department's efforts to prevent episodes of behavioral dyscontrol and, thereby, reduce and restrict the utilization of seclusion as an emergency, time-limited, safety measure. Physical, social, and cultural environments that promote each person's well-being and preserve the rights and dignity of all patients, staff members, and visitors shall be maintained. Assessment, communication, training, and collaboration shall be the tools to ensure that each patient's needs, abilities, and functional limitations are understood and addressed in a productive, constructive manner. As such, the use of seclusion as a means of coercion, discipline, convenience, or retaliation by staff shall not be tolerated.


Seclusion shall only be utilized as a time-limited, emergency safety measure for patients who are at imminent risk of physically harming themselves or others, and only after all other therapeutic interventions have failed or are found to be inappropriate. Each episode of seclusion shall be followed by debriefing sessions of involved patients and staff to afford all involved parties with the opportunity to discuss their feelings and concerns related to the seclusion episode. Within this process, events and/or feelings leading up to the episode of behavioral dyscontrol shall be reviewed with the patient to determine collaboratively what interventions might have been utilized to either prevent the episode or to help the patient regain control earlier. The information collected during the debriefing process shall then be incorporated into the patient's written plan of care.

Training and Education

A comprehensive Behavioral Management Strategies Training Program, which is responsive to continuous performance improvement studies, shall be provided on an annual basis to all employees participating in the care of patients. Only staff members who have attended and demonstrated competence in the training requirements shall be permitted to participate in the implementation, maintenance, and discontinuation of seclusion.

Performance Improvement

The Department of Mental Health and Addiction Services is committed to preventing, reducing, and ultimately eliminating the use of seclusion by cultivating staff attitudes and behaviors that reflect patient-centered values and best practice standards. To this end, the leadership of all DMHAS facilities shall be expected to maintain continuous performance improvement activities that deliberately and efficiently review and monitor all episodes of seclusion use for clinical justification, unusual incidents or patterns of utilization, and evidence of appropriate monitoring



and documentation, with a focus on modifying and enhancing administrative oversight, clinical practice, and training initiatives as indicated.

PROCEDURAL TEMPLATE FOR FACILITY POLICY AND PROCEDURE DEVELOPMENT

Leadership/Staffing

1. The leadership of all DMHAS facilities shall adopt and communicate the department's philosophy on the use of seclusion to all staff with direct care responsibility.
2. The leadership of all DMHAS facilities shall ensure that staffing levels and assignments are established to minimize circumstances that give rise to seclusion use and to maximize safety when seclusion is used. [*Staffing levels are based on staff qualifications, the physical design of the environment, diagnosis, co-occurring conditions, acuity, activity levels, and age and developmental functioning of individuals served.*]

Patients' Rights

3. Patients have the right to be free from the use of seclusion, of any form, as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion may only be used as an emergency intervention to prevent immediate or imminent injury to the patient and to others when other less restrictive measures such as redirection or verbal de-escalation have been found to be ineffective.
4. If seclusion is used, it must be used in accordance with the patient's plan of care, used in the least restrictive manner possible and ended at the earliest possible time.
5. The type of physical intervention selected takes into consideration information learned from the patient's initial assessment.
6. The use of seclusion is **not** based on the patient seclusion history or solely on a history of dangerous behavior, but these factors are considered in the risk assessment for imminence of dangerousness.


Initial Assessment at Admission

7. An initial assessment of each individual at the time of admission or intake is conducted to obtain information about the individual that could help minimize the use of seclusion.
8. During the initial assessment, the patient and/or family are asked to identify:
 - a) techniques, methods, or tools that would help the individual control his/her behavior. These techniques represent the patient's personal safety preferences that are assessed on admission and updated periodically. (*See Commissioner's Policy Statement on Personal Safety Preferences*);
 - b) pre-existing medical conditions or physical disabilities/limitations that would place the individual at greater risk during seclusion;

- c) history of sexual or physical abuse that would place the individual at greater psychological risk during seclusion; and
 - d) the existence of an advance directive.
9. At the time of the initial assessment/intake:
- a) the individual and/or family is informed of the facility's philosophy on the use of seclusion to the extent that this conveyance is not clinically contraindicated at that time;
 - b) the role of the family, including their notification of a seclusion episode, is discussed with the individual and as appropriate with the family. Appropriateness is determined based on the individual's preferences with respect to his/her right to privacy.
 - c) the facility determines whether the individual has an advance directive with respect to behavioral healthcare, and ensures that direct care staff are made aware of it.

Assessment and Orders for the use of Seclusion

10. PRN orders are not permitted for the use of seclusion.
11. A physician is required to directly assess a patient (face to face) prior to writing a **new order** for the use of seclusion.
12. In the event that a physician is not readily available, a Registered Nurse may initiate the use of seclusion in an emergency. In such a case:
- a) the nurse then calls the physician immediately to obtain the order;
 - b) describes the nature of the emergency and the rationale for procedure;
 - c) consults with the physician about the patient's physical and psychological condition;
 - d) documents the order and rationale on the Physician's Order Sheet; and
 - e) documents the same in the patient's medical record.
13. If the physician receives a call from the Registered Nurse seeking an order for seclusion, he/she:
- a) reviews with staff the physical and psychological status of the patient;
 - b) determines whether seclusion should be continued;
 - c) supplies staff with guidance in identifying ways to help the patient regain control in order for seclusion to be discontinued, and
 - d) supplies the telephone order.
14. If the physician did not initiate the use of seclusion, he/she assesses the patient's condition face to face within 1 hour of the initiation of seclusion and then:
- a) works with the patient and staff to identify ways to help the patient regain control;
 - b) makes necessary revisions to the patient's treatment plan;
 - c) countersigns the telephone order with date and time of countersignature;
 - d) documents in the medical record the results of his/her assessment;
 - e) documents rationale for the decision to use seclusion including less restrictive interventions attempted; and
 - f) documents the effect of seclusion on the patient's treatment plan.

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15. **All seclusion orders** are written for a maximum of three hours at which time seclusion is terminated and other forms of treatment attempted unless the patient remains an imminent danger to self or others as assessed by the physician or nurse.
 16. Following a direct assessment by the physician or nurse, a patient is removed from seclusion at the earliest possible time which may be prior to the time specified in the order, and must be documented in the patient's medical record.
 17. If seclusion is terminated before the time-limited order expires, a new order is obtained to reinstitute seclusion if the patient is at imminent risk of harming himself/herself or others and non-physical interventions are again determined not to be effective.
 18. By the time the original order expires and every three hours thereafter, if seclusion continues, a face to face re-evaluation of the patient is conducted by the physician or the nurse. This includes re-evaluation of the efficacy of the patient's treatment plan and working with the patient to identify ways to help him/her regain control.
 19. When seclusion is continued, as a result of the re-evaluation, a written or telephone order is given by the physician for no longer than three hours.
 20. **Renewal (telephone) seclusion orders** obtained by the nurse (in which a physician does not perform a face to face direct assessment) are only permitted between the hours of 11:00 p.m. and 8:00 a.m. Telephone orders may be obtained every three hours if:
 - a) the physician performed a face to face assessment after 8:00 p.m.; and
 - b) the Registered Nurse determines that the termination of seclusion poses an immediate or imminent risk of injury to the patient or to others.
 21. The physician issuing the order between the hours of 11:00 p.m. and 8:00 a.m. conducts a face to face re-evaluation within 8 hours and countersigns the telephone orders with date and time.
 22. If someone other than the treating physician writes the order, the treating physician is consulted as soon as possible.
 23. The patient's Attending Physician ensures that the use of seclusion is in accordance with a written modification to the patient's treatment plan.
 24. Cases in which a behavioral management program is required for a patient who is frequently assessed to require seclusion will adhere to the Commissioner's Policy Statement on Behavioral Management Programs.

Notification of the Patients Family



25. Cases in which the patient has consented to inform his/her family, the family is notified as agreed upon each time seclusion is initiated. This also applies to notification of the conservator of person or the patient's health care agent and/or legal advocate.

Implementation of Seclusion

26. A team approach is preferable for the implementation of the seclusion procedure to assure safety of both patient and staff.

Observation and Care of the Patient in Seclusion

27. The condition of the patient who is in seclusion is monitored on continuous observation and regularly assessed and re-evaluated at initiation of seclusion and every 15-minutes thereafter.
28. Physical restraint may not be used in combination with seclusion. After the first hour, a patient in seclusion may be continuously monitored using simultaneous video and audio equipment if this is consistent with the patient's condition or wishes.
29. The 15-minute assessment includes, as appropriate to the use of seclusion:
- a) signs of any injury associated with the use of seclusion;
 - b) nutrition/hydration;
 - c) hygiene and elimination;
 - d) physical status and comfort;
 - e) mental status and preferences for conversation, silent companionship, distraction (e.g., radio, television), or quiet time by him/herself;
 - f) readiness for discontinuation of seclusion; and
 - g) vital signs to be taken hourly.
30. Staff provide active treatment and discuss with the patient strategies for meeting behavioral criteria for the discontinuation of seclusion.

Discontinuation of Seclusion

31. Early in the seclusion process, the patient is informed of the rationale for seclusion and is involved in a process of identifying behavioral criteria for its discontinuation. These behavioral criteria shall be observable, specific, and individualized and may include the following:
- no longer threatening (verbal/physical);
 - quiet;
 - appears in control;
 - sleeping; and
 - no longer expressing/exhibiting self injurious intent.
32. Seclusion is discontinued as soon as the patient meets the specified behavioral criteria for discontinuation.



Post-Seclusion Debriefing

33. The patient and staff participate in a debriefing about the seclusion episode in order to reduce the recurrent use of seclusion.
34. The patient and if appropriate and available, the patient's family, participate in a debriefing with staff who were involved in the episode.
35. Each episode is debriefed as soon as possible, and at most within 24 hours after the episode.

36. Debriefing is used for the patient, staff, and the unit to assist staff and patients in:
- a) identifying what led to the incident and what could have been handled differently;
 - b) ascertaining that the patient's physical well-being, psychological comfort and preferences, and right to privacy were addressed;
 - c) counseling the patients involved for any trauma that may have resulted from the incident;
 - d) when indicated, modifying the patient's treatment plan; and
 - e) assisting all patients and staff who may have been involved or affected by the incident.
37. Information from the debriefing is used in performance improvement activities.

Documentation

38. The medical record contains documentation of the admission/intake assessment which addresses:
- a) that the patient and/or family was informed on the facility's policy on the use of restraint and seclusion.
 - b) any pre-existing medical conditions or physical disabilities that would place the patient at greater risk during restraint and seclusion;
 - c) any history of sexual or physical abuse that would place the patient at greater risk during restraint or seclusion;
 - d) personal safety preferences which are part of every initial assessment. (*Refer to Commissioner's Policy Statement on Personal Safety Preferences*)
39. The medical record contains documentation of each episode of seclusion including the following: (*See attached sample forms for documentation of seclusion/restraint*)
- a) the circumstances that led to its use;
 - b) the use and effectiveness of ***non-physical interventions***;
 - c) the ***rationale*** for the type of physical intervention selected;
 - d) ***notification*** of the individual's family/conservator/legal advocate, when appropriate;
 - e) ***written orders*** for use;
 - f) ***identification with the patient*** of behavioral criteria for discontinuation of seclusion;
 - g) ***each telephone order*** received from a licensed independent practitioner;
 - h) ***each face to face evaluation*** and re-evaluation of the individual;
 - i) ***15-minute assessments*** of the individual's status;
 - j) ***assistance provided*** to the individual to help him or her meet the behavioral criteria for discontinuation of seclusion;
 - k) ***continuous monitoring***;
 - l) ***debriefing*** of the individual with staff;
 - m) ***death or injuries*** that are sustained and treatment received for these injuries; and
 - n) ***evaluation*** of effectiveness of interventions with seclusion.
40. Documentation is accomplished in a manner that allows for the collection and analysis of data for performance improvement activities.

41. In cases in which a behavior management program has been developed for the patient in seclusion, documentation in the medical record shall take place in the same manner as described in items 38 and 39 at the time the seclusion order is written or renewed and at the time the face to face assessment is done.

Monitoring and Oversight

42. Routine monitoring and oversight of the use of seclusion shall include:

- a) All episodes of seclusion will be reviewed at the unit level each day by unit leadership to ensure that the interventions are justified and that documentation of this evidence is complete. In addition, all episodes of seclusion will be monitored by the Nursing Department with the goal of reducing the use of restrictive procedures. In order to review justification and investigate unusual incidents or patterns of utilization, and ensure appropriate monitoring and documentation, the Director of Nursing or his/her designee will review the order initiating or continuing seclusion on a daily basis. All seclusion data will be gathered by the Inpatient Service and sent to the Director of Nursing or his/her designee on a monthly basis. This information is reviewed in an on-going way by a facility's performance improvement team, reported to the OOC on a quarterly basis, and reported in aggregate to the State Board of Mental Health and Addiction Services, Connecticut Legal Rights Project/Office of Protection and Advocacy on a quarterly basis.
- b) Should a patient be involved in 2 or more episodes of seclusion or spend 12 hours or more in seclusion within a 24 hour period, the attending psychiatrist will review the patient's care with the facility Medical Director or his/her designee.
- c) Should a patient be involved in 6 or more episodes of seclusion or spend 24 hours or more in seclusion within a 48 hour period, the facility Medical Director or his/her designee will consider development of a Behavioral Management Program. (See CPS #22d, Behavioral Management Program)
- d) Should a patient be involved in 12 or more episodes of seclusion or spend 48 hours or more in seclusion within a one week period (with all previous efforts having been reviewed at the facility level), the facility Medical Director or his/her designee will notify the DMHAS Office of the Medical Director for review and consultation regarding the patient's on-going care needs. The consultation is documented in the patient's medical record.

Staff Training and Competence

43. Training requirements shall include, but not be limited to, staff being able to demonstrate an understanding and/or competence:
- a) of the underlying causes of behavioral dyscontrol experienced by the individuals they serve;
 - b) that aggressive behavior is at times related to a medical condition, e.g., fever, hypoglycemia;
 - c) of how their own behaviors can affect the behaviors of the individuals they serve;
 - d) in the use of prevention techniques and alternatives to handle symptoms, behaviors, and situations that historically have prompted the use of a restrictive procedure;
 - e) in verbal defusing or de-escalation strategies, or use of time out;
 - f) in approved physical holding techniques and take-down procedures;

- g) in the differences between life threatening and other levels of physical restraint holds;
 - h) in the differences between permissible holds and pain compliance techniques;
 - i) in recognition of signs of physical distress in individual being held or secluded; and
 - j) in first aid and cardiopulmonary resuscitation, and emergency medical response
[*leadership ensure an appropriate number of staff are available at all times to respond in a medical emergency as detailed in the facility plan for providing emergency services*].
44. Training requirements for staff authorized to perform 15-minute assessments on individuals in seclusion include:
- a) taking vital signs and interpreting their relevance for the physical safety of the individual in seclusion;
 - b) recognizing nutritional/hydration needs;
 - c) assessing physical and mental status and comfort;
 - d) assisting individuals in meeting behavioral criteria for the discontinuation of seclusion;
 - e) recognizing readiness for the discontinuation of seclusion; and
 - f) recognizing when to contact a medically trained licensed independent practitioner or emergency medical services in order to evaluate and/or treat the individual's physical status.
45. Additional training requirements for staff who are authorized to initiate seclusion and perform evaluations/re-evaluations in the absence of a licensed independent practitioner include:
- a) recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and
 - b) the identification of behavioral criteria for the discontinuation of seclusion and how to assist individuals in identifying and meeting these criteria.
46. Individuals who have experienced seclusion are involved in staff training in order to help staff understand their perspectives. These individuals whenever possible shall contribute to the training curricula and participate in staff training.

Notification of Clinical Leadership

47. Clinical leadership (as defined by each facility) is informed of all instances in which patients experience extended or multiple episodes of seclusion as follows:
- a) patients who remain in seclusion for more than **12 hours**; or
 - b) patients who experience **2 or more separate episodes** of restraint and/or seclusion of any duration within **12 hours**; and
 - c) thereafter, leadership is notified **every 24 hours** if the above conditions continue.
48. Clinical leadership uses this information to discharge its clinical responsibility by::
- a) assessing whether additional resources are required to facilitate discontinuation of seclusion;
 - b) developing or accessing additional strategies for assisting the patient in achieving behavioral control; and

- c) minimizing recurrent instances of seclusion.

Performance Improvement

- 49. The facility collects data on the use of seclusion in order to monitor and improve its performance of processes that involve risks.
- 50. The facility collects data on seclusion:
 - a) in order to ascertain that seclusion was used only as an emergency intervention;
 - b) to identify opportunities for incrementally improving the rate and safety of seclusion use; and
 - c) to identify any need to redesign care processes.
- 51. Data is collected and aggregated monthly on all seclusion episodes and classified for all settings/units/locations by:
 - a) shift;
 - b) staff who initiated the process;
 - c) the length of each episode;
 - d) date and time each episode was initiated;
 - e) day of the week each episode was initiated;
 - f) the type of seclusion used;
 - g) whether injuries were sustained by the individual or staff;
 - h) age of the individual;
 - i) gender of the individual;
 - j) whether personal safety preferences were considered; and
 - k) whether appropriate debriefings were conducted.
- 52. Data on seclusion are analyzed (*see above*) with particular attention to:
 - a) multiple instances of seclusion experienced by an individual within a 12 hour timeframe;
 - b) the number of episodes per individual;
 - c) instances of seclusion that extend beyond 12 consecutive hours; and
 - d) use of psychoactive medications as an alternative for, or to enable, discontinuation of seclusion.
- 53. Physicians (Licensed Independent Practitioners) participate in measuring and assessing use of seclusion for all patients within their facilities.

Reporting of Seclusion

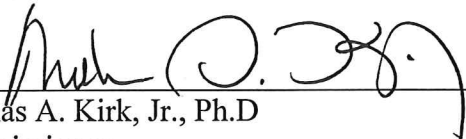
- 54. The use of seclusion shall be reported to the Office of the Commissioner (OOC), monthly in accordance with the guidelines promulgated by the OOC.
- 55. A patient injury as a result of seclusion use is reported via the incident reporting system to the Office of the Commissioner.
- 56. Each facility is to report to the Office of the Commissioner any death that occurs while a

patient is in seclusion or in which it is reasonable to assume that a patient's death is a result of seclusion use.

57. Following consultation with the Office of the Commissioner, each facility is to report to HCFA any death that occurs while a patient is in seclusion or in which it is reasonable to assume that a patient's death is a result of seclusion.
58. If the use of seclusion results in any incident of serious injury or death of persons in seclusion, the Commissioner shall report any serious injuries or death due to seclusion to the Office of Protection and Advocacy for Persons with Disabilities.
59. Data on seclusion are sent to the NASMHPD Research Center who forwards these data to JCAHO in compliance with the ORYX Initiative.

Policies and Procedures

60. Facility policies and procedures include appropriate detail that addresses **prevention** of the use of seclusion and, when employed, guide their use. Policies and procedures address:
 - a) staffing levels;
 - b) competence and training of staff;
 - c) the initial assessment of the individual;
 - d) the role of non-physical techniques in the management of behavior;
 - e) time-out;
 - f) limiting the use of seclusion to emergencies;
 - g) notification of the individual's family when seclusion is initiated;
 - h) ordering of seclusion by a licensed independent practitioner;
 - i) in-person evaluations of the individual in seclusion;
 - j) initiation of seclusion by an individual other than a licensed independent practitioner;
 - k) time-limited orders;
 - l) reassessment of an individual in seclusion;
 - m) monitoring the individual in seclusion;
 - n) discontinuation of seclusion;
 - o) post-seclusion practices (debriefing);
 - p) reporting injuries and deaths to the organization's leadership and to the appropriate external agencies consistent with applicable law and regulation;
 - q) documentation; and
 - r) integration of data collection and analysis on seclusion into performance improvement activities for violence prevention and seclusion reduction.



Thomas A. Kirk, Jr., Ph.D
Commissioner

This directive replaces Commissioner's Interim Policy Statement No. 22-A Seclusion dated October 15, 1999.

PART I - Initial Assessment by RN and MD☐ General Psychiatry Division

Patient Name: _____

☐ Whiting Forensic Division

Shift: _____

☐ Addiction Services Division

Unit: _____

MPI # _____ *Print or Addressograph Imprint***ORDER START DATE: _____ TIME: _____ am/pm****Describe the Emergency/Imminent Risk, Precipitating Factors, Specific Interventions Utilized, and Patient Response Prior to Initiation of Seclusion/Restraint (If necessary use additional Progress Note sheet(s) and attach.):**

RN: _____

Less Restrictive Interventions Attempted (Check all used):

- | | | |
|---|--|---|
| <input type="checkbox"/> Active listening | <input type="checkbox"/> Physical exercise | <input type="checkbox"/> Re-direction |
| <input type="checkbox"/> Decrease environmental stimuli | <input type="checkbox"/> PRN/Stat medication offered/taken | <input type="checkbox"/> Time Out |
| <input type="checkbox"/> Diversion/distraction | <input type="checkbox"/> Medication refused | <input type="checkbox"/> Verbal support/reassurance |
| <input type="checkbox"/> Immediacy prevents less restrictive intervention | <input type="checkbox"/> Problem-solving/attempts to resolve | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Increase level of observation or interaction | <input type="checkbox"/> Quiet Time | _____ |
| <input type="checkbox"/> Personal Safety Preference Form Consulted | | |

Description of Emergency/Imminent Risk, Direct Assessment of the Patient and Justification of the Seclusion/Restraint:

MD: _____

Psychotropic Medication Status Prior to**Seclusion/Restraint**

- | | |
|--|--|
| _____ | <input type="checkbox"/> Routine psychotropic medication ordered and taken |
| _____ | <input type="checkbox"/> Routine psychotropic medication ordered and NOT taken |
| _____ | <input type="checkbox"/> No routine psychotropic medication ordered |
| Attending MD Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | <input type="checkbox"/> PRN Psychotropic medication taken |
| Intervention Support Team Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No administered | <input type="checkbox"/> STAT/emergency psychotropic medication |

Patient Name: _____ MPI#: _____

Justification for Seclusion/Restraint (Check all that apply):
☐ Imminent risk of serious physical assault
 ☐ Imminent risk of serious self destructive behavior

 "All Available"/Code (Behavioral Management Emergency) Called? ☐ Yes ☐ No
Procedure (Check ONE of the following categories: Seclusion, Ambulatory Restraint OR Non-Ambulatory Restraint)Seclusion
☐ Locked (1)
☐ Unlocked (2)
☐ Emory Craig Cubicle Bed (TBI Unit) (2)
☐ Other: _____
Restraint – Ambulatory
☐ 2 point (wrist) (1)
☐ 4 point (wrist & ankles) (1&2)
☐ Other Ambulatory (3)
Restraint - Non-Ambulatory
☐ 4 point to bed (1,2 &4)
☐ 4 point & waist to bed (1,2,3&4)
☐ Posey Net Restraint to bed (6)
☐ Restraint chair waist only (3&5)
☐ Restraint chair 4 point & waist (1,2,3&5)
☐ Other Non-Ambulatory (9): _____
Criteria for Discontinuation of ProcedurePatient Notified of Criteria for Discontinuation? ☐ Yes ☐ No ☐ Unable

Assessment Criteria for Discontinuation Include:

- Patient is no longer threatening (verbal/physical)
- Patient is not struggling against restraints
- Patient is quiet
- Patient appears in control
- Patient is sleeping
- Patient is no longer expressing/exhibiting self injurious intent

Notification of Conservator/Family (completed by Attending Psychiatrist/designee OR On-Call MD)Does the Patient have a Conservator of Person? ☐ Yes ☐ No

If yes – Conservator notified by: _____ Name of Conservator: _____

Conservator's response: _____

Was family notified? (Check for release of information and/or directives recorded on the Personal Safety References Form CVH-469)

☐ No, patient unable to give permission
☐ No, patient prohibits notification
☐ Other directive: _____
☐ Yes - Family notified by: _____ Name of Family Member: _____

Family's response to notification of seclusion/restraints:

☐ No further calls necessary ☐ Continue to call for each episode ☐ Notify once a week (8:00 am – 4:30 pm)
☐ Other: _____

Signature (Assessing RN)

Date

Time

am/pm

Printed Name: _____

Signature (Evaluating MD)

Date

Time

am/pm

Printed Name: _____

I have reviewed this seclusion/restraint episode for accuracy and completion of all applicable protocols.

Signature (Nursing Supervisor)

Date

Time

am/pm

Printed Name: _____

PART II - NURSING OBSERVATION AND CARE OF THE PATIENT

Patient Name: _____

Unit: _____


ORDER START DATE: _____

TIME: _____ am/pm

MPI#: _____

Print or Addressograph Imprint

TIME	STAFF	BEHAVIORAL OBSERVATION (Use Codes Below)	CARE (Use Codes Below)	VITAL SIGNS	INTERVENTION (Use Codes below)	RN HOURLY ASSESSMENT AND PROGRESS NOTE (Include physical condition and behavioral assessment)	RN INIT
1 q 15 min				Pulse: Resp.: Pulse: Resp.: B/P:		Behavioral Assessment: Physical Condition: Vitals: [] Stable [] Other: _____ Skin: [] Intact [] Other: _____ Circulation: [] Adequate [] Other: _____ Injury Noted? [] Yes [] No	
2				Pulse: Resp.: Pulse: Resp.: B/P: Temp.		Behavioral Assessment: Physical Condition: Vitals: [] Stable [] Other: _____ Skin: [] Intact [] Other: _____ Circulation: [] Adequate [] Other: _____ Injury Noted? [] Yes [] No	
3				Pulse: Resp.: Pulse: Resp.: B/P:		Behavioral Assessment: Physical Condition: Vitals: [] Stable [] Other: _____ Skin: [] Intact [] Other: _____ Circulation: [] Adequate [] Other: _____ Injury Noted? [] Yes [] No	
						INTERVENTION(S) ATTEMPTED FOR REDUCTION/REMOVAL OF SECLUSION/RESTRAINT	INIT
1	Beating on objects	11 Aggressive response to disturbing internal stimuli	A Ambulated	E ROM exercise provided (q2 hr)	PE Review of precipitating event with patient		
2	Trying doors	12* Quiet	B Bathed or Showered (at least q 24 hr)	F Fluids offered/taken (q2 hr)	ER Review emotional response with patient		
3	Pacing	13* Appears calm	C Circulatory Assessment	G Meal served	AR Offer/discuss alternative actions/responses with pt		
4	Assaultive, Combative	14* Sleeping	Adequate (q 15 min)	H Bedpan, bathrm. offered/taken (q2 hr)	MED Offer patient medication		
5	Restless, Struggling	15* Other: _____	(skin warm to touch, pulse present, able to place one finger under restraint.)	I Medication Administered	REL Offer patient & demonstrate/practice relaxation strategies		
6	Agitated			J Position changed	ACT Offer patient distracting/calming activities (e.g. reading, story telling, music, etc.)		
7	Threatening gestures						
8	Verbalizing self abusive or self						

destructive behaviors 9 Verbal threats to harm 10 Yelling, Screaming, Shouting	Discontinuation RN to Confer with MD	and respiratory adequate	followed by an "R" will indicate the care was offered but was refused	LRP Implement less restrictive procedure		
				DC Discontinued Procedure		
				R Refused – Any reduction attempt code followed by "R" will indicate intervention was offered but refused by patient		

Patient Name: _____

MPI # _____ Print or Addressograph Imprint

☐ General Psychiatry Division☐ Whiting Forensic Division☐ Addiction Services Division Unit: _____

Reorder Date of Seclusion/Restraint: _____ Time: _____ am/pm

Original Start Date: _____ Start Time: _____ am/pm

Describe Specific Interventions Utilized and Patient Response Prior to this Reassessment/Reorder of Seclusion/Restraint:

Attending MD Notified? ☐ Yes ☐ No ☐ N/A

Justification for Seclusion/Restraint (Check all that apply):

☐ Imminent risk of serious physical assault☐ Imminent risk of serious self destructive behavior

Less Restrictive Interventions Attempted (Check all used):

☐ Active listening☐ Physical exercise☐ Re-direction☐ Decrease environmental stimuli☐ PRN/Stat medication offered/taken☐ Time Out☐ Diversion/distraction☐ Medication refused☐ Verbal support/reassurance☐ Immediacy prevents less restrictive intervention☐ Problem-solving/attempts to resolve☐ Other _____☐ Increase level of observation or interaction☐ Quiet Time

Psychotropic Medication Status During the Prior 3 Hours of Seclusion/Restraint:

☐ Routine psychotropic medication ordered and taken☐ PRN psychotropic medication taken☐ Routine psychotropic medication ordered and NOT taken administered☐ STAT/emergency psychotropic medication☐ No routine psychotropic medication ordered

Procedure (Check ONE of the following categories: Seclusion, Ambulatory Restraint OR Non-Ambulatory Restraint):

SeclusionRestraint – AmbulatoryRestraint - Non-Ambulatory☐ Locked (1)☐ 2 point (wrist) (1)☐ 4 point to bed (1,2 &4)☐ Unlocked (2)☐ 4 point (wrist & ankles) (1&2)☐ 4 point & waist to bed (1,2,3&4)☐ Emory Craig Cubicle Bed (TBI Unit) (2)☐ Other Ambulatory (3)☐ Posey Net Restraint to bed (6)☐ Other: _____☐ Restraint chair waist only (3&5)☐ Restraint chair 4 point & waist (1,2,3&5)☐ Other Non-Ambulatory (9): _____

Criteria for Discontinuation of Procedure

Patient Notified of Criteria for Discontinuation? ☐ Yes ☐ No ☐ Unable

Assessment Criteria for Discontinuation include:

- Patient is no longer threatening (verbal/physical)
- Patient is not struggling against restraints
- Patient is quiet

- Patient appears in control
- Patient is sleeping
- Patient is no longer expressing/exhibiting self injurious intent

Date _____ Time _____ am/pm _____

Signature (Evaluating MD)

Printed Name

DISTRIBUTION:

Original – Chart (file in date order in the Progress Note Section)

Photo Copy – Data Entry

DISCONTINUATION/CONTINUATION OF SECLUSION/RESTRAINT

☐ **DISCONTINUATION of Seclusion/Restraint**

☐ **CONTINUATION of Seclusion/Restraint**

Patient Name: _____ MPI#: _____

DISCONTINUATION:

Procedure is: ☐ Seclusion ☐ Restraint

End Date of Seclusion/Restraint: _____ Time: _____ am/pm

Patient Debriefing: ☐ Yes ☐ No

If no, explain:

Staff Debriefing: ☐ Yes ☐ No

If no, explain:

Patient Community Meeting:

☐ Yes ☐ N/A

CONTINUATION:

Procedure is: ☐ Seclusion ☐ Non-Ambulatory Restraint ☐ Ambulatory Restraint

Ordered at: Date: _____ Time: _____ am/pm *RN to initiate a new Part II – "Observation and Care of the Patient" form (CVH-480b)*

By: _____ *MD to initiate a Part III "Reassessment of Seclusion/Restraint"*

(Name of Physician)

form (CVH-480-c) when a face to face is required

RN Summary Progress Note (Check one)

☐ **Discontinuation:** Include patient's mental and physical condition, response to procedure, recommended alternative strategies to prevent recurrence. Include patient's and staff's perspective.

☐ **Continuation:** Include commentary on patient's mental and physical condition, patient's response to procedure, alternative strategies attempted during the 3-hour interval, patient's behaviors that justify imminent risk.

Physical Condition:

Vitals: ☐ Stable ☐ Other: _____

Circulation: ☐ Adequate ☐ Other: _____

Skin: ☐ Intact ☐ Other: _____

Occurrence of Injuries:

☐ Injuries to patient on initiation of Seclusion/Restraint

☐ Injuries to patient while in Seclusion/Restraint

am/pm

☐ No injuries to patient occurred

If Patient Injured:

MD Notified at: _____

Date

Time

Signature RN: _____ Date _____ Time _____ am/pm

Printed Name: _____

I have reviewed this seclusion/restraint episode for appropriateness and accuracy and completion of all applicable protocols.

Signature Nursing Supervisor: _____ Date _____ Time _____ am/pm

Printed Name: _____

DISTRIBUTION: **Original - Chart** (file behind corresponding Part I or Part III)) **Photo Copy** (*both sides*) – **Data Entry**

CVH-480d **CONNECTICUT VALLEY HOSPITAL**
Rev. 10/01 **Seclusion/Restraint**
PATIENT DEBRIEFING

Patient Name: _____

- ☐ General Psychiatry Division
☐ Whiting Forensic Division
☐ Addiction Services Division Unit: _____

MPI # _____ *Print or Addressograph Imprint*

Date: _____ Time: _____ am/pm

1. INCIDENT DESCRIPTION

- A. The purpose of completing this form is to **prevent** a similar incident from happening again. Please describe your behavior that led up to your being placed in seclusion or restraint. *Where were you? What happened? What did you do?*

- B. What *had* you been **thinking** about at the time you were getting upset? _____

- C. What *were* you **feeling** upset about? _____

- D. In the **week prior** to the incident, have any of the following factors been true for you:

- ☐ Poor appetite or eating
☐ Physical illness
☐ Difficulty sleeping
☐ Problems with peers
☐ Other major changes or stressors in your life: _____

- E. What **other factors** may have made you more sensitive or vulnerable to losing control at this time? _____

2. POST INCIDENT MANAGEMENT

- A. What would you **change** so that you are able to calm yourself and effectively cope with a similar situation? _____

File in Progress Note section following the corresponding "Discontinuation" portion of Part II "Observation & Care of the Patient"

- B. What are the *consequences* of your behaviors? _____
- _____
- _____
- _____

3. PREVENTION

- A. What could have *been done differently* to prevent the situation from happening? Think of *specific points along the way* (like a crossroad) where you could have done something differently that might have made the outcome of the incident better.

- B. What are the things that *you* could do differently if faced with a similar situation again? What can you *plan ahead* to do to cope better without losing control?

- C. What could *Staff* do differently if faced with a similar situation again? _____

Completed by:

Staff Signature and Title Printed Name

Date: _____ Time: _____ am/pm